

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-033155

STATE FILE NUMBER

AMENDED

Registration District No. 149  
FILED OCT 11 1961

Primary Registration District No. 1002 Registrar's No. 4818

|   |                           |   |                               |  |   |   |                |  |                             |
|---|---------------------------|---|-------------------------------|--|---|---|----------------|--|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON  |                           |   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE MO b. COUNTY CLAY  |   |   |                |  |                             |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN KANSAS CITY  |                           | Length of stay in 1b<br>10 YRS  |                               | c. CITY OR TOWN KANSAS CITY  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                |  |                             |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION TRINITY LUTHERAN   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                               | d. STREET ADDRESS (If outside, give location)<br>4225 N. WALNUT  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |                |  |                             |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>Leland B. Thomas  |                           |   |                               | 4. DATE OF DEATH<br>Month Day Year<br>SEPT 26 1961   |   |   |                |  |                             |
| 5. SEX<br>MALE  | 6. COLOR OR RACE<br>WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br>10-6-1901 | 9. AGE (last birthday)<br>59   | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HR |  |                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>SUPERVISOR GENERAL MOTORS CO   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>MARTINSVILLE IND.  |                               | 11. BIRTHPLACE (City and state or country)<br>U.S.A.   |   | 12. CITIZEN OF WHAT COUNTRY   |                |  |                             |
| 13a. FATHER'S NAME<br>Charles O Thomas  |                           | 13b. MOTHER'S MAIDEN NAME<br>Nellie Badgley   |                               | 14. NAME OF HUSBAND OR WIFE<br>Dorothea Thomas   |   |   |                |  |                             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No   |                           | 16. SOCIAL SECURITY NO.   |                               | 17. INFORMANT<br>Dorothea Thomas 4225 N. WALNUT  |   |   |                |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE COR PALMONARY EDEMA<br>DUE TO (b) CONGESTIVE HEART FAILURE<br>DUE TO (c) ACUTE MYOCARDIAL INFARCTION & DUE CORONARY ARTERY THROMBOSIS |                           |   |                               | INTERVAL BETWEEN ONSET AND DEATH<br>1 hr.<br>3 wks<br>3 wks<br>1 wk  |   |   |                |  |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |                           |   |                               | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |                |  |                             |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                           | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |   |                |  |                             |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year   |                           | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                               | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE  |                |  |                             |
| 21. I attended the deceased from 1-22-57 to 9-25-61 and last saw him alive on Sept 25, 1961<br>Death occurred at 125/A m on the date stated above, and to the best of my knowledge, from the causes stated.   |                           |   |                               | 22a. SIGNATURE<br>(Degree or title)<br>Edw H Fischer MD  |   |   |                | 22b. ADDRESS<br>306 E 21 <sup>st</sup> NKC 16 mo | 22c. DATE SIGNED<br>9-26-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>REMOVAL  |                           | 23b. DATE<br>9-27-1961  |                               | 23c. NAME OF CEMETERY OR CREMATORY<br>CENTENIAL CEM.   |   | 23d. LOCATION (City, town, or county)<br>Bloomington, Ind.                            |                | (State)  |                             |
| 24. FUNERAL DIRECTOR<br>D.W. Newcomer's Sons N.K.C.   |                           |   |                               | 25. DATE RECD. BY LOCAL REG.<br>9-17-61  |   | 26. REGISTRAR'S SIGNATURE<br>Keith Long   |                |  |                             |

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed John V. Herrick, Jr.

Licensed Embalmer No. 4848

P. O. Address K.C. 17, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.